Mental Welfare Commission for Scotland

Report on announced visit to:

Lyon Ward, Rohallion Secure Care Clinic, Murray Royal Hospital, Perth, PH2 7BH

Date of visit: 11 October 2023

Where we visited

The Rohallion Clinic incorporates both low and medium secure hospital care for men across five wards. It is a regional unit providing inpatient services primarily for the north of Scotland. Lyon Ward is a 12- bedded low secure rehabilitation ward and on the day of our visit, we found 10 beds occupied and two individuals out on pass.

The Commission last visited Lyon Ward in July 2019, and made no recommendations for this visit.

We heard from the staff in Lyon Ward that it took until the start of 2023 for them to have almost returned to the regular ward routine that was in place prior to the Covid-19 pandemic. However, there was still an impact of third sector staffing and accommodation shortages that was having an impact on discharge planning.

Who we met with

We met with six individuals and reviewed all of their notes. We also met with one set of the relatives, we spoke with the service manager, charge nurse, staff nurse, nursing assistant and activity nurse.

Commission visitors

Gordon McNelis, nursing officer

Lesley Paterson, senior manager (practitioners)

Margaret White, ST6 in the psychiatry of intellectual disability

What people told us and what we found

Care, treatment, support and participation

On meeting individuals and hearing their feedback, we heard that their experience of care and treatment was positive. Individuals told us that although Lyon Ward was a low secure ward, they liked the independence and personal space that having a key to their room provided. They also mentioned the benefits that came with having controlled access to laptops. The model of care in Lyon Ward focused on maximising individual's skills in preparation for discharge to a community setting. Emphasis was placed on supporting individuals to organise their meal preferences, budgeting and taking turns to cook for the group on a rota basis. Although some individuals expressed their anxieties about the different expectations that related to these activities, in general, the feedback we had was that learning these activities and skills was beneficial and increased their confidence.

Care records

Information on individual's care and treatment was held in the electronic record system, EMIS. Unfortunately, on the day of visit EMIS was not accessible across the Rohallion Clinic site, and we were unable to gain access to review the care records, care plans, continuation notes and multidisciplinary meeting records. This report is based on information gathered from staff in Lyon/Rohallion Clinic during our visit, and from the pre-visit meeting that took place with the Commission area coordinator, ward staff and Rohallion Clinic senior management.

We had access to documentation that was available in paper files. We found that the information in these was out-of-date. We believe there are risks associated with having two systems, especially when one of which does not contain current information. The Commission recognises that when IT systems are not available, then access to clinical information can prove difficult. We suggested that a contingency plan be put in place to ensure that service delivery was maintained and that paper copies of key pieces of information must be maintained and up-to-date.

Recommendation 1:
Managers should ensure that all clinical information is primarily stored electronically on EMIS to reduce the risks associated with having two separate recording systems however, any paper copies of key information must be current.

Care plans

Due to being unable to view the electronic records, we had requested care plans be forwarded to the visit coordinator to view; at the time of writing this report, we had not received the requested files/information.

We were told individual care plans had been developed by the quality improvement team, however this was at an early stage and there was work had still to be done on this.

We heard that previously, person-centred care plans and individual participation in the process was variable. The principle of participation should promote an individual being involved in decisions about their care, and include involvement in their own care planning. We were pleased to hear that the principle of participation and the individual's right to participate in decisions that affected them had been progressed and that this had resulted in an

improvement in individualised care plans over the past six months. We were told by managers that they had taken guidance from the Commission's Person Centred Care Plans Good Practice Guide, and also from NHS Tayside Standards for Person Centred Care Planning.

Lyon Ward staff advised us that health checks were monitored through physical observations that were carried out on a monthly basis, with additional checks in place if required. The ward had good links with GPs, the dietician and podiatrist, who attended the ward weekly to address each individual's relevant needs. Where individuals were affected by chronic conditions, the GP took the lead and arranged a referral to the appropriate service. We were pleased to hear that all individuals in Lyon Ward took part in a physical health review prior to their routine Care Programme Approach (CPA) review meetings. We found that coordinating these checks with regular and routine CPA meetings created an ideal opportunity to maintain, identify and discuss the physical health of individuals in a multidisciplinary setting.

Recommendation 2:
Managers should ensure that care plans are person-centred, detail each individual's identified needs, interventions in place and evidence individual participation. These should be regularly reviewed and their quality audited.

Multidisciplinary team (MDT)

A range of professionals were involved in the provision of care and treatment in the ward. This included psychiatry, nursing staff, physiotherapy, occupational therapy and a dietician. We were made aware of staffing challenges with three consultant psychiatrists moving to different posts, however these positions were being advertised. There were links in place with community services who offered joint activity groups that focused on the subsequent stages of discharge and transition to a CMHT. MDT meetings were held weekly, however, we were unable to review the meeting records, as this information was also held on EMIS.

We heard that with a reduction in pharmacy staff, this has had an impact on the frequency of their attendance at MDT meetings; we were told they would attend for specific input when requested. During periods of nursing staff shortages, senior staff requested the same bank nurses who were familiar with the patients in Lyon Ward and the layout of the environment.

Use of mental health and incapacity legislation

Lyon Ward is a low secure forensic ward, and all individuals in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedures (Scotland) Act 1995. The individuals we met with during our visit had a good understanding of their status and rights where they were subject to detention under these Acts.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and corresponded to the medication being prescribed.

Rights and restrictions

Lyon Ward continues to operate with a locked door which was proportionate to the level of risk identified with the individual group. A locked door policy was in place.

The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. Although we were unable to view online documentation, we were told there was a good level of promotion and encouragement for individuals to participate and complete advance statements. Awareness of advance statements was being progressed with staff, who raised this at the six-monthly CPA meetings. Each individual's preference to agree or decline making an advance statement was documented at this time.

We heard that there was good access to advocacy, and that this service regularly attended the ward to meet with individuals. Advocacy services for both medium and low secure wards were based in Rohallion Clinic however, due to expected changes with advocacy staff in early 2024, this service will soon be based externally, away from the site. We were assured that the same standard of service would continue to be available to individuals during this transition and beyond. In preparation of this change, there have been forums where the views of the patients were collected, with reassurance being given that access to, and the standard of the current advocacy service would continue to be available to individuals as and when requested. Rohallion staff would also continue to liaise with the new advocacy service to ensure support was provided during this transition.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital, including the mechanism for review of the restrictions and informing the individual of their right to appeal against these. Where an individual is made a specified person in relation to this legislation, and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised and that the need for specific restrictions to be regularly reviewed. When reviewing individuals specified persons paperwork, we were concerned with what appeared to be a blanket policy of all individuals' mail having to be opened in front of nursing staff, however not all individuals were specified for correspondence. We requested all specified persons reasoned opinions were checked to confirm whether these restrictions were necessary and authorised for each individual.

Our specified persons good practice guidance is available on our website:
https://www.mwcscot.org.uk/node/512

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Individuals have their human rights respected at key points in their treatment.

Recommendation 3:
Managers should undertake an audit to ensure that all restrictions are required, proportionate and legally authorised under specified person's legislation and there is evidence of regular review.

Activity and occupation

Lyon Ward was described as a self-sufficient ward that focused on building confidence, skills and knowledge through participation in structured activity. This was supported by encouraging individuals to engage with activities of day-to-day activity groups, facilitated by occupational therapists (OT) and technical instructors.

In addition to this, emphasis was also placed on the importance of individual and ward activity with allocated ward staff designated to the activity nurse role on a daily basis. Although this role was an addition to the regular team, due to the frequency of escorted outings and individual activity, it was a helpful resource that supported further opportunities for individual's care and treatment during their stay in hospital. We consider that developing a dedicated activity staff member for the ward would be beneficial for ensure that there are opportunities for individuals to participate in valued and meaningful structure. We were pleased to hear that the patient's views and preference had been gathered at regular one-to-one and group meetings, and that theses had been used when arranging the ward activity timetable.

We were told delivery and participation of activities were not solely provided by the OT and activity nurses, but that all staff across the MDT engaged with working on the therapeutic relationship between themselves and the patients. We heard that each individual's areas of interest and activities were linked with community mental health teams, who contributed to supporting individuals to the next stage of transition into the community setting.

We were told there had been improvements with staff documenting engagement in activity. Areas where improved recording had been identified by the quality improvement group were to increasingly offer activities to individuals, have better recording of this and whether the individual had accepted or declined to participate. We were unable to review on the day of our visit however, we look forward to reviewing this at our next visit. We were pleased to see Lyon Ward's focus on structure and activity and the importance of individual inclusion was an example of good practice and one that we would encourage the ward to continue.

Recommendation 4:
Managers should consider appointing a dedicated activity co-ordinator to Lyon Ward to support the continuation and expansion of the good practice of offering person-centred activities to individuals.

The physical environment

Lyon Ward was in phase 2 of NHS Tayside's operational anti-ligature work. Work continued to be carried out on individuals' bedroom areas with anti-ligature furniture installed and plans for 'door top alarms' to be fitted to en-suite areas. Observational doors had also been fitted to ensure safe monitoring of individuals whilst being able to provide privacy and maintain dignity to individuals.

Any other comments

Delayed discharges

During our visit, we heard that there were two individuals whose discharge from hospital had been delayed for an extended period of time. When a person's discharge is delayed, this means that they remain in hospital despite being clinically fit for discharge. Although suitable

accommodation in the private sector had been identified for these individuals, this was still under construction and there were issues with the building that had contributed to the delay. Other reported factors in the delays related to issues around the recruitment of social care staff, and these advertised posts had not been recruited to.

Whilst the Commission acknowledges certain factors remain out with the control of health authorities who are responsible for the care of individuals, discharge planning should begin on admission. Delayed discharges impact negatively on both the individual whose transfer is delayed, and also on those individuals who require admission to these specialist services but are unable to be admitted due to the lack of beds.

Summary of recommendations

Recommendation 1:
Managers should ensure that all clinical information is primarily stored electronically on EMIS to reduce the risks associated with having two separate recording systems however, any hard copies of key information must be current.

Recommendation 2:
Managers should ensure that care plans are person-centred, detail each individual's identified needs, interventions in place and evidence individual participation. These should be regularly reviewed and their quality audited.

Recommendation 3:
Managers should undertake an audit to ensure that all restrictions are required, proportionate and legally authorised under specified person's legislation and there is evidence of regular review.

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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